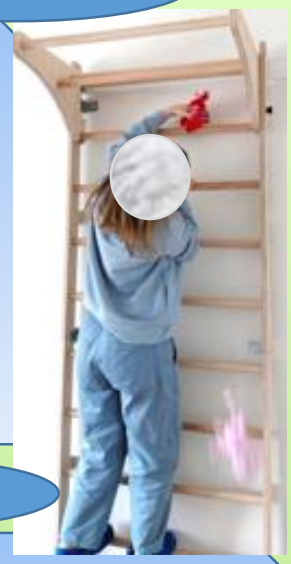
Case Study- doing OT well using Ayres Sensory Integration Therapy in Residential Social Care. By Emma Hardie

Resident Profile and strengths and participation challenges

'we have fun'



28 year old female, diagnosis of Attention Deficit Hyperactive Disorder with an autistic profile and moderate to severe learning disabilities. Complex presentation including communication difficulties, self injurious behaviours- skin picking and head banging, ripping clothes and damaging property (usually her own).

A great sense of humour and a wide range of activities she identifies as enjoying. Currently unable to participate in many of these activities due to high levels of distress and arousal levels. Loves to be active but often becomes distressed prior to or when commencing the activity, displays risky behaviours and/or self-sabotages and relieved when the decision is taken out of her hands. Her parents and support staff are keen for to be able to enjoy participation in meaningful activities and improve quality of life. The resident has named 2 activities she loves and able to enjoyably participate in. These are well practiced activities in which she has developed a good skill base and a sense of mastery/accomplishment for.

A comprehensive sensory diet has been in place that includes passive and active sensory strategies to incorporate throughout her day and environmental adaptations.

Assessment

Adult/Adolescent Sensory History care-givers questionnaire completed separately with parents and support staff indicating difficulties with modulation and discrimination in tactile system and difficulties with proprioceptive system and motor planning- gave valuable information on what to assess in more depth.

Clinical Observations (structured, non-standardized observations of a person's sensory processing and its effect on movement and behaviour) and **informal observations** were used as part of the fully comprehensive sensory assessment.

'it helps me'

Hypothesis

1. The resident presents as **over-responsive to tactile input** and finds it difficult to maintain a calm- alert state of arousal, particularly during her morning routine but also throughout the day.
2. The resident also presents with tactile and proprioceptive discrimination difficulties and poor body scheme. In combination with significant motor planning difficulties including anticipating and imitating movements her sensory integration difficulties indicate **samatodyspraxia.**

'i'm relaxed'

Goals

Distal Goals (resident and proxies) - morning routine can be very distressing and those who know her well wish this was easier for her so she can move on with her day and preferred activities.

- Within 12 weeks resident will be able to complete her morning routine with verbal support from staff without having an adverse reaction at least 3 mornings a week.

The resident has indicated a desire to do new and novel activities and increase the variety of activities she feels a sense of mastery/accomplishment over, naming yoga and going to the gym.

- Within 12 weeks the resident will be able to assume 4 simple yoga poses independently

Proximal Goals (therapy goals)- increase tolerance to tactile input and improve tactile and proprioceptive discrimination, body scheme, and praxis.

- Within 12 weeks, the resident will place their hands into a wet messy play tray for at least 2 minutes to retrieve hidden items with minimal verbal encouragement.
- Within 12 weeks the resident will independently imitate 4 out of 5 novel body positions during her 1:1 session without visual feedback and with verbal encouragement from the therapist.

Above goals are scaled using **Goal Attainment Scale** which will be used to **outcome the intervention** after 12 sessions have been completed.

'can we do this again'

Intervention, challenges and solutions in meeting fidelity

Fidelity ensures the intervention adheres to the core theoretical principles of Ayres Sensory Integration- that the intervention delivered is ASI, it is addressing the working hypothesis and conclusions (differences) can be linked to the therapy/intervention itself.

Structural elements- **Physical space** and **suspended equipment-** setting is a 10 bedded busy home with no suspended equipment or therapy rooms. Sessions are planned for quieter times when others are out and a quiet room can be found. Egg chair swing outside has been used and a session is planned for the playground.

Process elements-**Establishing a calm alert level of arousal**. Resident helps carry larger items to session and loves deep pressure with a yoga ball. Further exploration- she loves the vibrating pillow and linear movement on egg chair. Deep pressure is administered as required throughout. Graded exposure to tactile input, in the form of messy play, has been completed whilst using the egg chair. Ensuring the resident is an **active collaborator** throughout and not having sessions too pre-planned or being directive. Resident helps OT prep for session, choosing which resources might be used. This gives time to process information and supports her to 'explore' during the session. OT gives options when required and taps into residents preferences to ensure she remains engaged and using her **intrinsic motivation to play**. Sessions are based around residents likes for example retrieving 'Lilo and Stich' toys from the climbing ladder, playing games over a yoga ball, retrieving small animal figures from messy play trays. Finding **the just right challenge** and spontaneously adapting activities throughout sessions. It is important for resident to succeed, whilst the task needs to be challenging enough to provoke an **adaptive response**. OT does not always get this right but it's becoming easier with the growth of the **therapeutic alliance.** Steep learning curve for OT but the sessions are **playful** and fun and although only part way through the intervention block, the residents progress can already be seen within sessions. OT is looking forward to seeing how ASI therapy transfers to residents occupations outside the session.

'I'll give it a go'

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